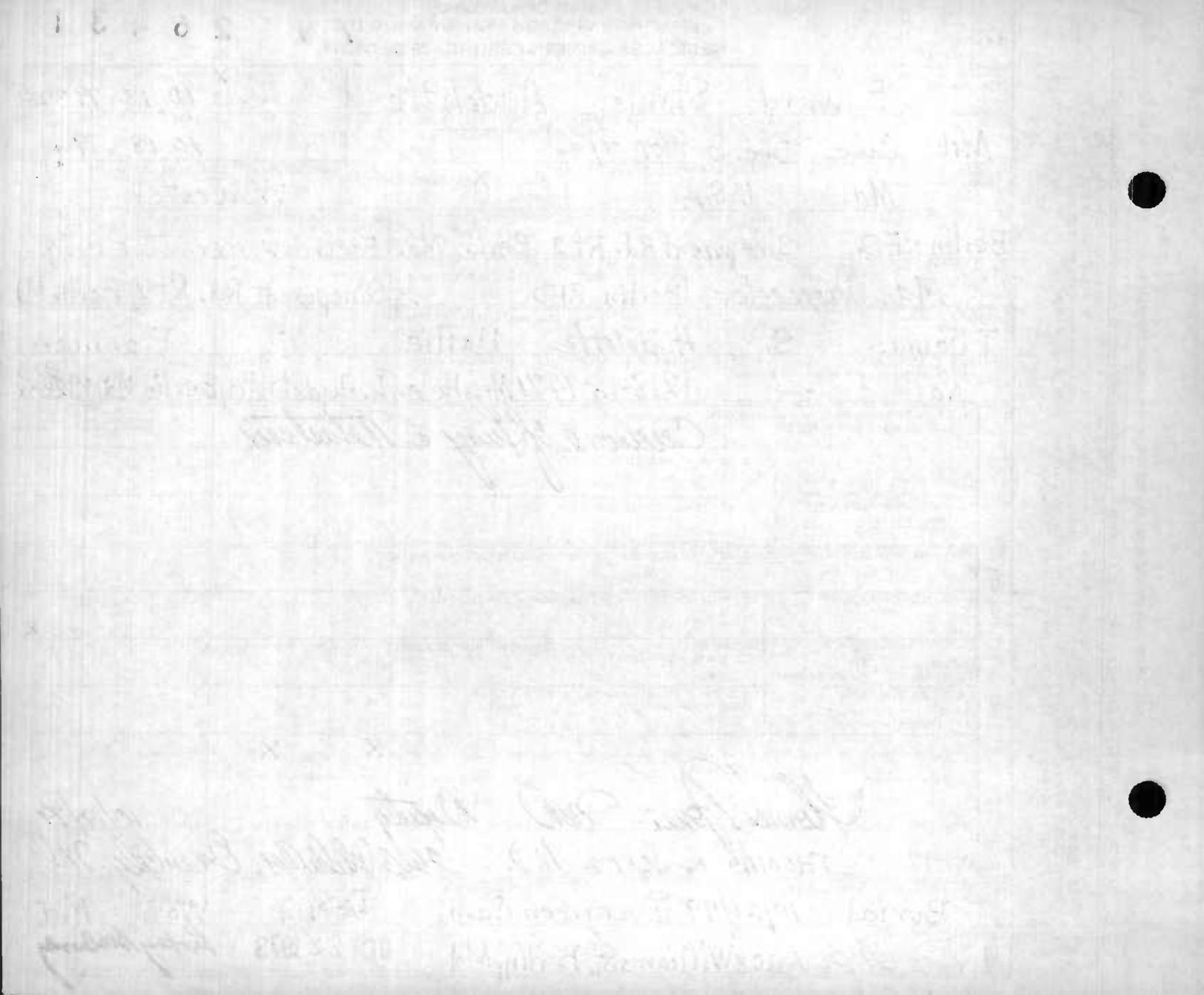


STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 9 26431

1- FOR STATE REGISTRAR		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		Edward	Stanley	Aydelotte	<input checked="" type="checkbox"/>	10 18	19	79	3:30P.M.	
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE IN YEARS LAST BIRTHDAY	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.				2c. DATE PRONOUNCED DEAD
Male		Cauc.	Dec. 3 1907 71	YRS.						10 18 19 79 M
11. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.		U.S.A.					Worcester			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Berlin RFD		Sinepuxent Rd. Rt.2 Berlin, Md.			Factory worker			Ice Mfg.		
13. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		13f. ADDRESS		
Md.		Worcester	Berlin RFD.			Sinepuxent Rd. Rt.2, Berlin Md.		323		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME					
Thomas		S.		Aydelotte	Hattie C. Freeman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		218-16-7471			Mrs. Helen L. Aydelotte, Berlin, Md. Rt 2 Box					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <u>Caerebral hemorrhage &amp; tetanus</u> DUE TO, OR AS A CONSEQUENCE OF  (b) _____ DUE TO, OR AS A CONSEQUENCE OF  (c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Thomas L. Jones, M.D.</i>		TITLE (SPECIFY) <i>Deputy</i>			MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			DATE SIGNED <i>10/19/79</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 10/21/79			23c. NAME OF CEMETERY OR CREMATORY Evergreen Cem.			23d. LOCATION CITY OR TOWN Berlin		
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR Oct 22 1979			25b. REGISTERED SIGNATURE <i>Helen L. Aydelotte</i>		
BP _____		Anna D. Burk, 108 Williams St, Berlin, Md.								

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "FRENCH" IN PENCIL IN THE CHIEF MEDICAL EXAMINEE ALONG PAGE 4 SHOULD BE FORWARDED TO THE FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSPORT PERMIT. PAGES 1 AND 2 SHOULD BE FILED AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of issue with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.				
1. FOR STATE REGISTRAR			2. DATE OF DEATH MONTH DAY YEAR									7b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			OCT. 9, 1979			4 <sup>10</sup> PM	
William EIFRED									BARNEY							
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH MONTH FEB. DAY 6 YEAR 1880			6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS.			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS HOURS MIN		
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY N.Y.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Hagerstown			10a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		10b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Interviewer U.S. Dept. of Labor		
10 CITY OR TOWN OF DEATH Snow Hill			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hermon House			12a. STREET ADDRESS Rt. 1, Mt. Hermon Road			12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland			13b. COUNTY Wicomico			13c. CITY OR TOWN Parsonsburg			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS (unknown)				
14. FATHER'S NAME FIRST (unknown)			15. MOTHER'S MAIDEN NAME FIRST (unknown)			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS Mrs. Jeannette Leathers Susquehanna, Pa.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Penal Failure</i> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Cardiovascular Disease</i> { DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> DUE TO, OR AS A CONSEQUENCE OF															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (the hospital) attended the deceased from <i>8/19/79</i> , 1979, to <i>10/9/79</i> , 1979, that (I) <input type="checkbox"/> lost saw the deceased alive on <i>8/19/79</i> , 1979, and that in my <input type="checkbox"/> (my) <input checked="" type="checkbox"/> (my) opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> (do not) view the body after death.																
22b. SIGNATURE <i>Thomas G. Jones MD</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>10/10/79</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas G. Jones, M.D.			22e. ADDRESS Snow Hill, Maryland													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 10/11/79			23c. NAME OF CEMETERY OR CREMATORIAL Cape Henlopen Crematory			23d. LOCATION Lewes, Sussex, Delaware			CITY OR TOWN		COUNTY		STATE
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Maryland			ADDRESS			25a. DATE REC'D. BY REGISTRAR OCT 15 1979			25b. REGISTRAR'S SIGNATURE <i>Portuguese</i>							

287-1100

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3, RETAIN PAGE 5 FOR YOUR RECORDS. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 26433
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI. DEATH MATED			MONTH	DAY	YEAR	2b. HOUR
DAMION			THOMAS	DAVIS		<input checked="" type="checkbox"/>	<input type="checkbox"/>	10 18 19 79	5:00 AM			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER T.YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR
MALE	Black	7 19 79	3			10 18 19 79			7:00 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Salisbury, Md.		USA						WORCESTER				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
NEWARK, Md.					none							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			Rt #2, Box 318			
Md	Worcester	Berlin				BERLIN, MD.						
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Matthew			Zelda Ann DAVIS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
						Zelda A. Davis			Express Above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Lobar Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>481</u> DUE TO, OR AS A CONSEQUENCE OF (c)												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?		
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE		M.D.			TITLE (SPECIFY) <u>Thomas L. Jones, M.D.</u> Deputy, MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			DATE SIGNED 10/18/79							
23a. BURIAL/CREMATION/REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL LOCATION OR TOWN			23d. LOCATION OR TOWN		23e. COUNTY		23f. STATE	
Burial		10-20-79		Evergreen Cem.			Berlin		Worcester		Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Jolley Memorial Chapel		Salisbury, Md.			NOV 1 1979			<u>Randy Kelley</u>				

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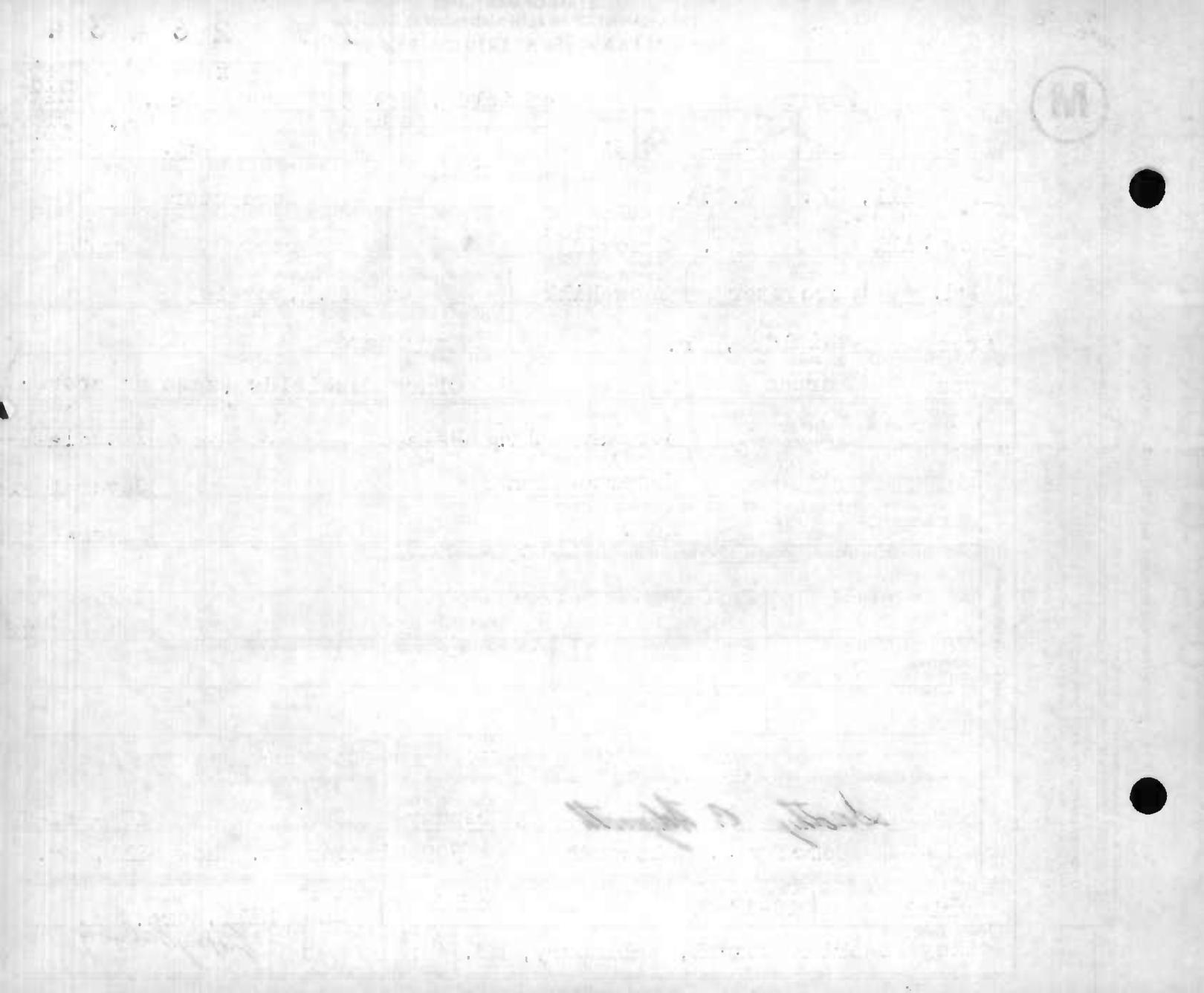
DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR.  
**PAGE 4** SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILE.  
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**2 6 4 3 4**

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH MATED	MONTH	DAY	YEAR	2b. HOUR HITA		
Preston			Deshields, Jr.			<input checked="" type="checkbox"/>			Oct. 9 1979	11:00 AM		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR 2:15 AM		
<input checked="" type="checkbox"/> M	Negro	7-22- 28	51			<input checked="" type="checkbox"/>			Oct. 9 1979			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Snow Hill, Md.		U.S.A.						Worcester				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Snow Hill		RT. #2 Box 103 B			Laborer			Seafood				
13a. STATE Md.		13b. COUNTY Worcester	13c. CITY OR TOWN Snow Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS RT. 3. Box 103 B			MD.			
14. FATHER'S NAME FIRST		MIDDLE	LAST		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST			
Preston Deshields, Sr.					Mary Ward							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		(YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			
yes		Korean				Clara Deshields (same as above)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF <b>Immediate</b> Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. } (b) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF <b>Several yr</b> (c) <b>ASHD</b> <b>Several yr</b>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Dorothy C. Holzworth</i> TITLE (SPECIFY) EXAMINER'S NAME (TYPE OR PRINT) Dorothy C. Holzworth M.D. MEDICAL EXAMINER DATE SIGNED 10 - 11-79 ADDRESS 309 Timmons St. Snow Hill, Md.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial	23c. NAME OF CEMETERY OR CREMATORY Hutts Memorial	23d. LOCATION CITY OR TOWN			23e. COUNTY	23f. STATE				
24. FUNERAL DIRECTOR NAME		ADDRESS	Jolley Memorial Chapel, Salisbury, Md.	25a. DATE REC'D. BY REGISTRAR OCT 19 1979			25b. RECORD NUMBER					

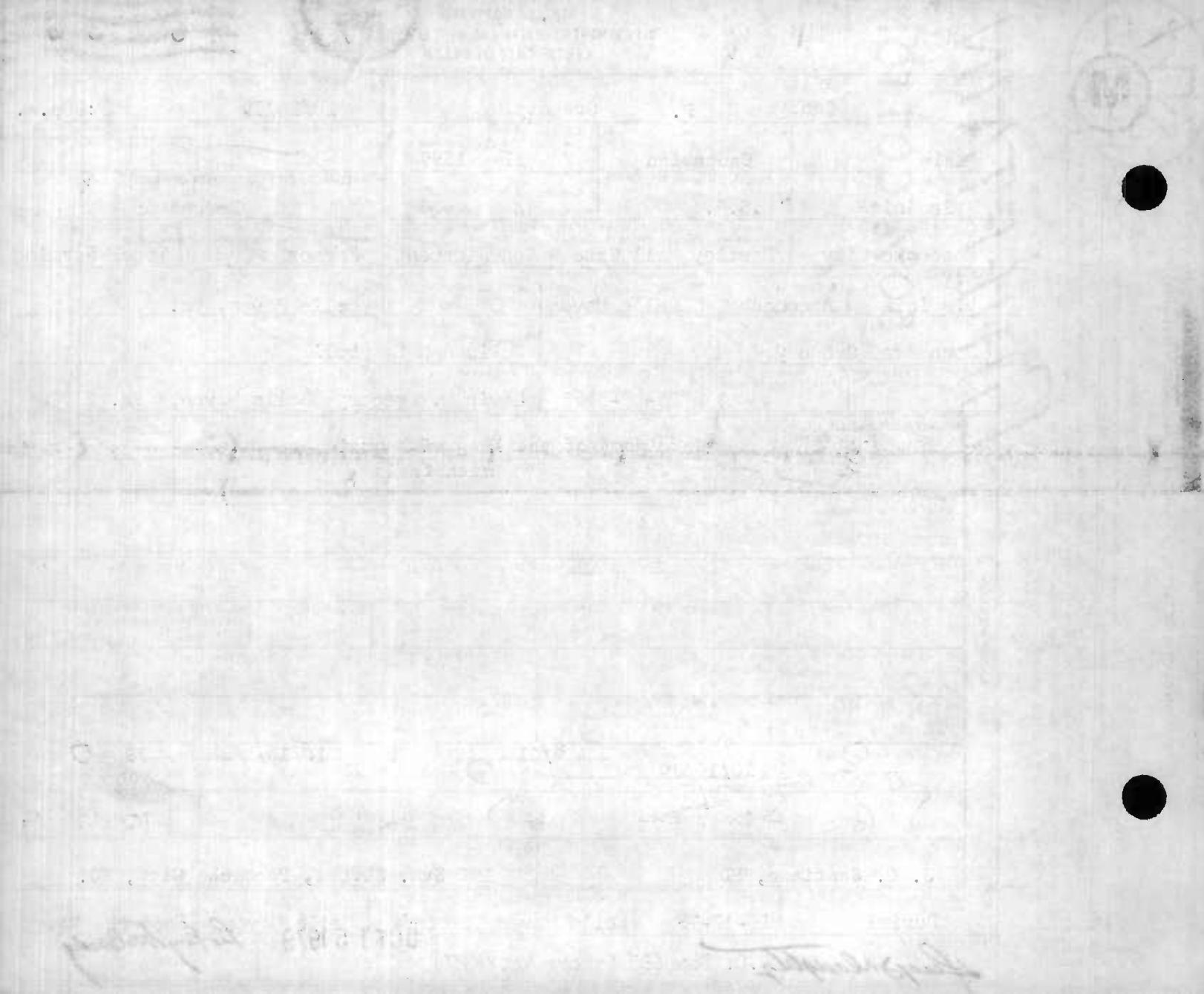


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.					
1 - FOR STATE REGISTRAR			20. DATE OF DEATH    MONTH    DAY    YEAR									2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	10/10/79									5:30p.m.		
George F. Gregory						DATE OF BIRTH MONTH    DAY    YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS    DAYS		IF UNDER 24 HRS HOURS    MIN			
3. SEX Male			4. RACE Caucasian			7    31    1899			80								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD								
10. CITY OR TOWN OF DEATH Pocomoke City			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartley Hall Care & Convalescent									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Truck Farming		
13a. STATE Virginia			13b. COUNTY Accomack			13c. CITY OR TOWN Belle Haven			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Belle Haven, Va.					
14. FATHER'S NAME John Adam Gregory									15. MOTHER'S MAIDEN NAME Julia Ann Campbell								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 225-48-3593			17. INFORMANT Levin M. Gregory			ADDRESS Belle Haven, Va. 23306			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of the lung with brain metastasis</b> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that (I) (we) attended the deceased from 8/21, 19 79, to 10/10, 19 79, that (I) (we) last saw the deceased alive on 10/10/79, 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We did/did not) view the body after death.																	
22b. SIGNATURE J. G. Santiano			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS 100 8th. Street, Pocomoke City, Md.			22f. DATE SIGNED 10-12-79					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-12-79			23c. NAME OF CEMETERY OR CREMATORIAL Belle Haven Cemetery			23d. LOCATION CITY OR TOWN Belle Haven			COUNTY		STATE			
24. FUNERAL DIRECTOR John J. Flaherty			ADDRESS P.O. Box 633 Exmore, Va. 23350			25. DATE RECEIVED BY DEPT. OF H. & M. H.			26. DATE ISSUED			27. APPROVING SIGNATURE					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 7 9 2 6 4 3 / 6											
1 - FOR STATE REGISTRAR			I DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR		
			VIRGINIA MARY MAGNESS						October 7, 1979		
3. SEX			4 RACE			5 DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		
female			white			April 24, 1891			88 yrs		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland			USA						Worcester		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Pocomoke			Hartley Hall Nursing Home			housewife					
13a STATE Maryland			13b COUNTY Worcester			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Market Street		
14. FATHER'S NAME FIRST Henry MIDDLE Clay LAST Inemer			15. MOTHER'S MAIDEN NAME FIRST Susan MIDDLE LAST Brown								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b SOCIAL SECURITY NO 215-05-1232			17 INFORMANT Virginia Lapen-Rehobeth, Md.			ADDRESS		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			Acute Pulmonary Edema								
			DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease								
			DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10-2, 1979, to 10-7, 1979, that (I) (we) lost sow the deceased alive on 10-7-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.											
22b. SIGNATURE Jesus S. Santiano			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10-8-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Jesus Santiano			22e. ADDRESS Pocomoke City, Maryland								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/8/79			23c. NAME OF CEMETERY OR CREMATORIAL Moreland Mem. Cem.			23d. LOCATION CITY OR TOWN Baltimore County STATE Baltimore Md.		
24 FUNERAL DIRECTOR NAME Scott S. Melon			ADDRESS Pocomoke City, Md.			25a. DECEASED BY 10-7-1979			25b. PLACED IN 10-8-1979		
BP _____											
DHMH-16 50M 7/77 (VRA 15 (4))											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR INFORMATION. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTHYGIE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 26437	
1 - STATE REGISTRAR				LAST								2a DATE KNOWN OF ESTI- DEATH MATED	
1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		IF UNDER 1 YR.		IF UNDER 24 HRS.		MONTH DAY YEAR	
JAMES I. MEARS												10 10 T9 77	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		2c. DATE PRONOUNCED DEAD	
M		NEGRO		5 - 3 - 23		56 yrs.		USA				10 10 1979 17PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH		2d. HOUR					
Snow Hill, NC		USA				Worcester		17PM					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION FOR MOST OF WORKING LIFE		12b. KIND OF BUSINESS OR INDUSTRY	
Snow Hill		208 S. Collins St.								Laborer		City	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		13f. ADDRESS			
MD		Worcester		Snow Hill		YES <input checked="" type="checkbox"/>		208 S. Collins St.		NEARS			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Frederick				Ballard		Georgianna		218-30-6032		Ady Lotte Deshields (Add. Somers above)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Myocardial Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) ASHD												1 hour	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Diabetes Mellitus												See. Yes	
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21c. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21d. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21e. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												DATE SIGNED 10-14-79	
ACTUAL SIGNATURE <i>Dorothy C. Hornsworth</i>		TITLE (SPECIFY) M.D. <i>Dorothy</i>		MEDICAL EXAMINER									
EXAMINER'S NAME (TYPE OR PRINT) <i>Dorothy C. Hornsworth</i>		ADDRESS <i>301 TOWNS 5 Syms Ave</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>10-16-79</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Ebenezer U.M.</i>		23d. LOCATION CITY OR TOWN <i>Snow Hill</i>		CITY OR TOWN		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME <i>Jolley Memorial Chapel - Sat. S. Md.</i>		ADDRESS <i>301 TOWNS 5 Syms Ave</i>		25a. DATE REC'D. BY REGISTRAR <i>OCT 19 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Fritzy Melvandy</i>							

MI



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 79 26438	
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 10 27 79									2b. HOUR M	
I. DECEASED NAME (TYPE OR PRINT) HLEX — NYAKAS, Jr.			4 RACE Caucasian			5 DATE OF BIRTH MONTH DAY YEAR Nov. 27 1914			6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
3 SEX M			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.				
10 CITY OR TOWN OF DEATH Berlin RFD#1			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RT.1, Box 356			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Agriculture				
13r. STATE Md. 13b. COUNTY Worcester			13c. CITY OR TOWN Berlin, RFD.			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Libertytown RFD#1				
14 FATHER'S NAME Alex			15. MOTHER'S MAIDEN NAME Nykas Elizabeth									LAST Olah	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. W.W.II 286-05-3952A			17 INFORMANT Mary N. Knapp			ADDRESS 630 Williams St. Berlin, Md.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocarditis 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (b) Hyperension DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.													
22b. SIGNATURE Clifford E. Schott M.D.			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 10/27/79				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Clifford E. Schott M.D.			22f. ADDRESS BERLIN, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/1/79			23c. NAME OF CEMETERY OR CREMATORIES Riverside Cemetery			23d. LOCATION CITY OR TOWN Berlin RFD#1			COUNTY Worcester STATE Md.	
24. FUNERAL DIRECTOR NAME Anna & Bushay			ADDRESS 108 Williams St. Berlin Md.			25a. DATE REC'D. BY REGISTRAR 77-1-79			25b. REGISTRAR'S SIGNATURE				



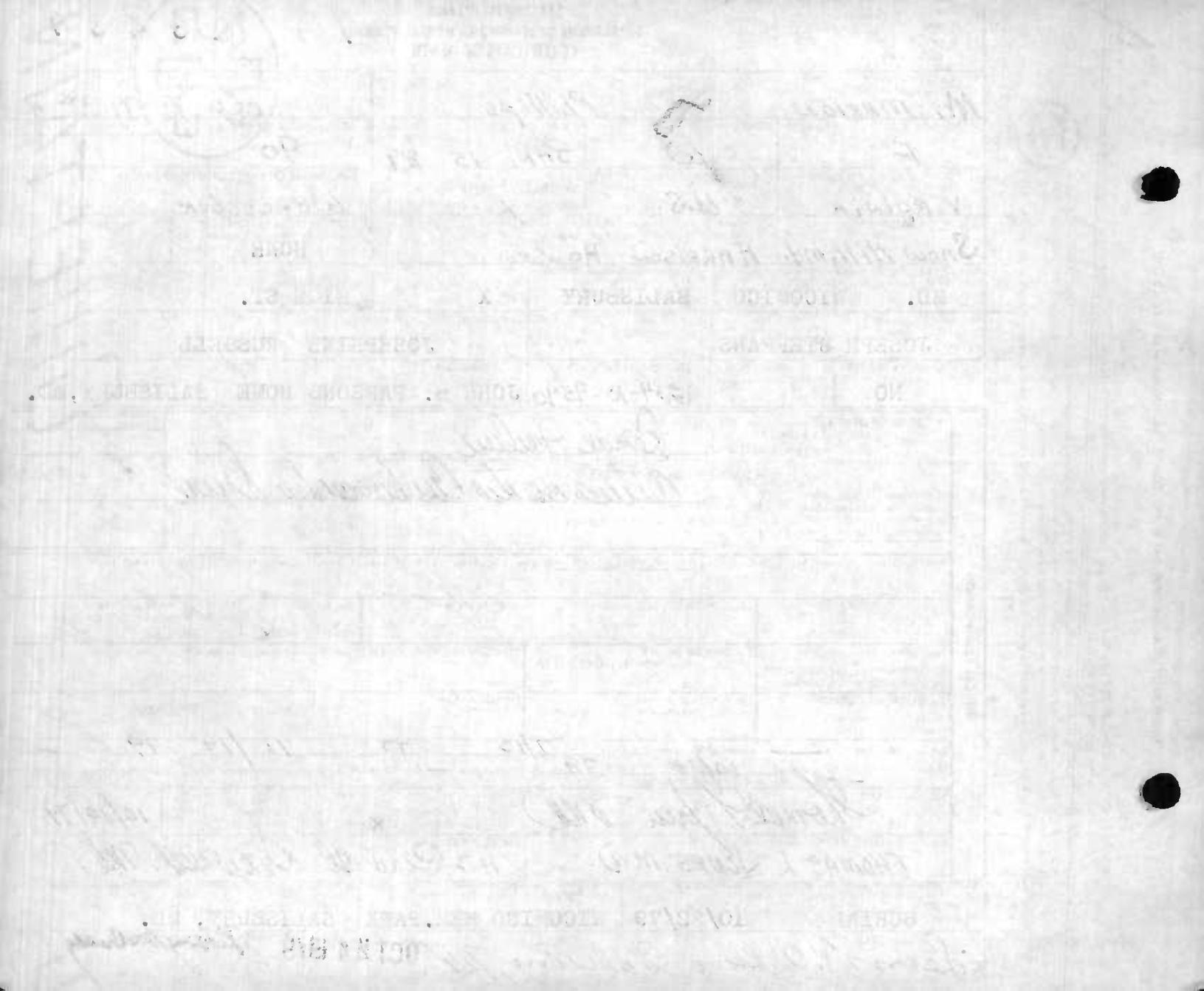
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
<i>M. Marion</i>						<i>Phillips</i>	oct. 19	79	3:20	A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
F		W		JAN. 15 89			90				
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.	
VIRGINIA		U.S.					Worcester				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. STATE MD.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Snow Hill, Md.		HARRISON House		13b. COUNTY WICOMICO			NONE				
13c. CITY OR TOWN SALISBURY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS HIGH ST.						
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
JOSEPH STEFFANS		JOSEPHINE RUSSELL									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS				
NO		214-10-9590		JOHN B. PARSONS HOME			SALISBURY, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Kenal Failure</i>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Osteosclerotic Cardiovascular Disease</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) <i>(the physician)</i> attended the deceased from <i>7/13</i> , 19 <i>77</i> , to <i>10/19</i> , 19 <i>79</i> , that (I) <i>(the physician)</i> saw the deceased alive <i>10/19</i> , 19 <i>79</i> , and that in my <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(the physician)</i> did not view the body after death.											
22b. SIGNATURE <i>Thomas L. Jones M.D.</i>		22c. DEGREE DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>10/19/79</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Thomas L. Jones M.D.</i>		22e. ADDRESS <i>112 Pearl St. Snow Hill, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/22/79		23c. NAME OF CEMETERY OR CREMATORIAL WICOMICO MEM. PARK			23d. LOCATION CITY OR TOWN SALISBURY, MD.		COUNTY		STATE
24. FUNERAL DIRECTOR NAME <i>Lewis R. Wilson Salisbury, Md.</i>		ADDRESS			25a. DATE REC'D. BY REGISTRAR OCT 24 1979			25b. REGISTRATION NUMBER <i>Temporary</i>			

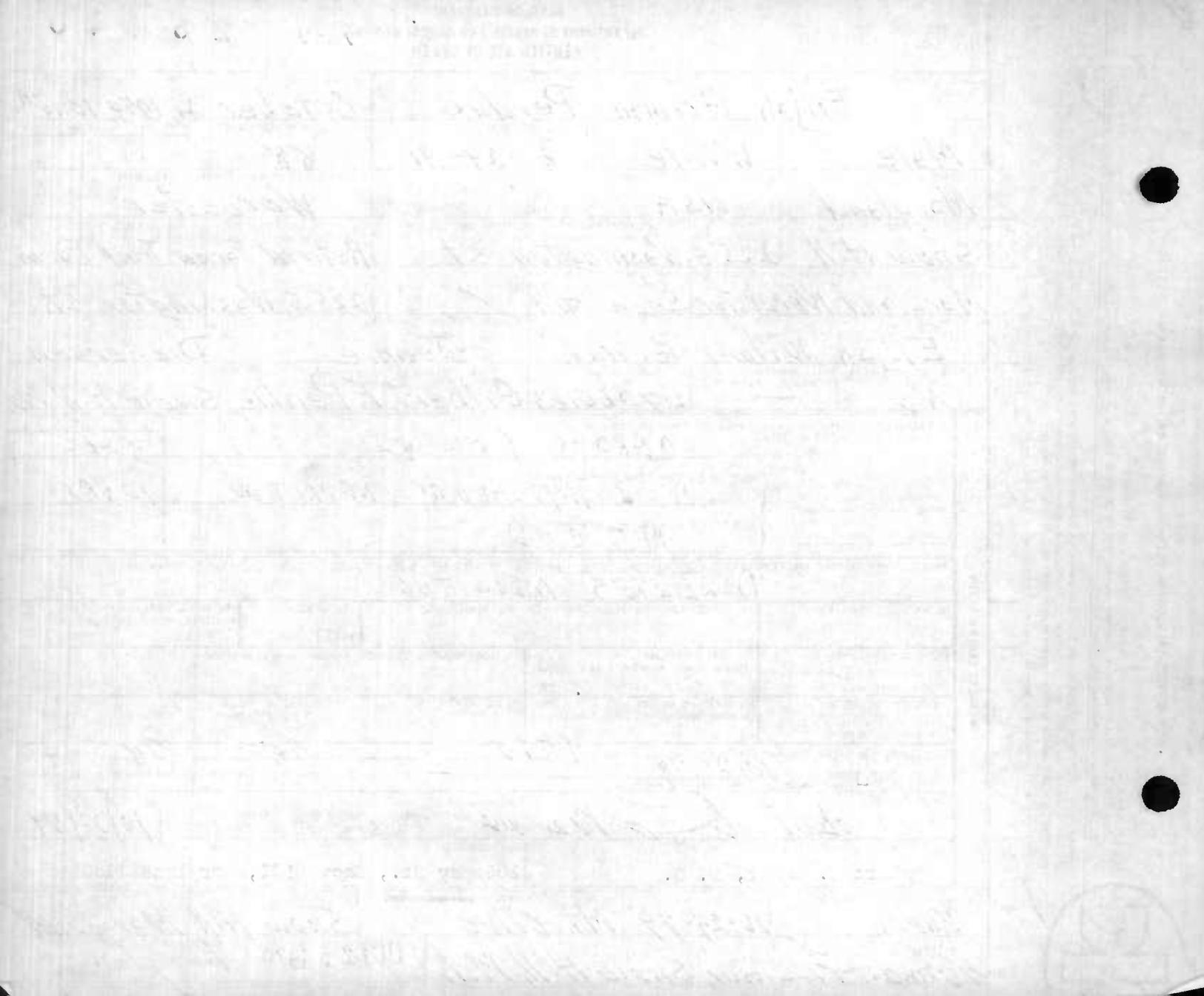


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 9 26440					
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			October 26 1979			10:15 AM					
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR					
Male			White			6 - 29 - 91			88			IF UNDER 24 HRS					
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS HOURS MIN					
Maryland			USA						Worcester			YRS.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY		
Snow Hill			225 S. Washington St.									Retired Farmer			Truck Farm		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
Maryland			Worcester			Snow Hill						225 S. Washington St.					
14. FATHER'S NAME			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME			Jennie Dickerson					
Elijah Wilmer Perdue																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No			—			217360163			Gilbert F. Perdue, Snow Hill MD			3 Hrs					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE MYOCARDIAL INFARCTION (c) NS CVD																	
DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES MELLITUS																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1960, 19, to Oct, 1979, that (I) (we) last saw the deceased alive on 10/21/79, 19, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not observe the body after death.																	
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/22/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			104 Bay St., Snow Hill, Maryland 21863								
Robert C. LaMar, M. D.																	
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)			23b. DATE 10-24-79			23c. NAME OF CEMETERY OR CREMATORY Mt. Olive			23d. LOCATION CITY OR TOWN Snow Hill			COUNTY Maryland		STATE			
24. FUNERAL DIRECTOR NAME Gorman & Sonnen, Snow Hill Md.			ADDRESS						25a. DATE REC'D. BY REGISTRAR Oct 25 1979			25b. REGISTRAR'S SIGNATURE Henry McCready					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3, RETAIN PAGE 5 FOR YOURSELF. PAGE 2 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS OF DEATH. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 9 26441					
1- FOR STATE REGISTRAR			2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR 10 12 1979 4PM									2b. HOUR 4PM					
1. DECEASED NAME (TYPE OR PRINT)			FIRST George A.			MIDDLE			LAST Saltzman			2c. DATE PRONOUNCED DEAD 10 12 1979 2PM					
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Oct 21 1905			6. AGE (IN YEARS LAST BIRTHDAY) 74 yrs.			7. IF UNDER 1 YR. MONTHS DAYS			8. IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE, STATE OR FOREIGN COUNTRY Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Worcester								
10. CITY OR TOWN OF DEATH Ocean City			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS) 9A St. Louis Ave.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembly Worker			12b. KIND OF BUSINESS OR INDUSTRY Garage Shop								
13a. STATE MD.			13b. COUNTY Anne Arundel			13c. CITY OR TOWN Severna Park			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rt. 1 Box 304					
14. FATHER'S NAME FIRST Adam			MIDDLE G.			LAST Saltzman			15. MOTHER'S MAIDEN NAME FIRST Maggie			MIDDLE LAST Zeller					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-10-0645			17. INFORMANT Nettie Davis - Sec. 13											
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b) and (c)). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410 - Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF Cerebral Myocardial Infarction Arteriosclerotic Cardiovascular Disease (c) DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN								
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>						and in my opinion								
ACTUAL SIGNATURE <i>Henry J. Barranco, M.D.</i>			TITLE (SPECIFY) <i>Deputy Medical Examiner</i>			DATE SIGNED <i>10/12/79</i>											
EXAMINER'S NAME (TYPE OR PRINT) <i>Thomas J. Barranco, M.D.</i>			ADDRESS <i>501 Ritchie Hwy, Severna Park</i>			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>10-15-79</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cem.</i>					
24. FUNERAL DIRECTOR NAME <i>Robert J. Barranco</i>			ADDRESS <i>501 Ritchie Hwy, Severna Park</i>			23d. LOCATION CITY OR TOWN <i>Woodlawn</i>			25a. DATE REC'D. BY REGISTRAR <i>OCT 15 1979</i>			25b. REGISTERED BY <i>John J. Kelly</i>					
DHMH - 17 (VR A15 ME(5)) 15M 7/76																	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

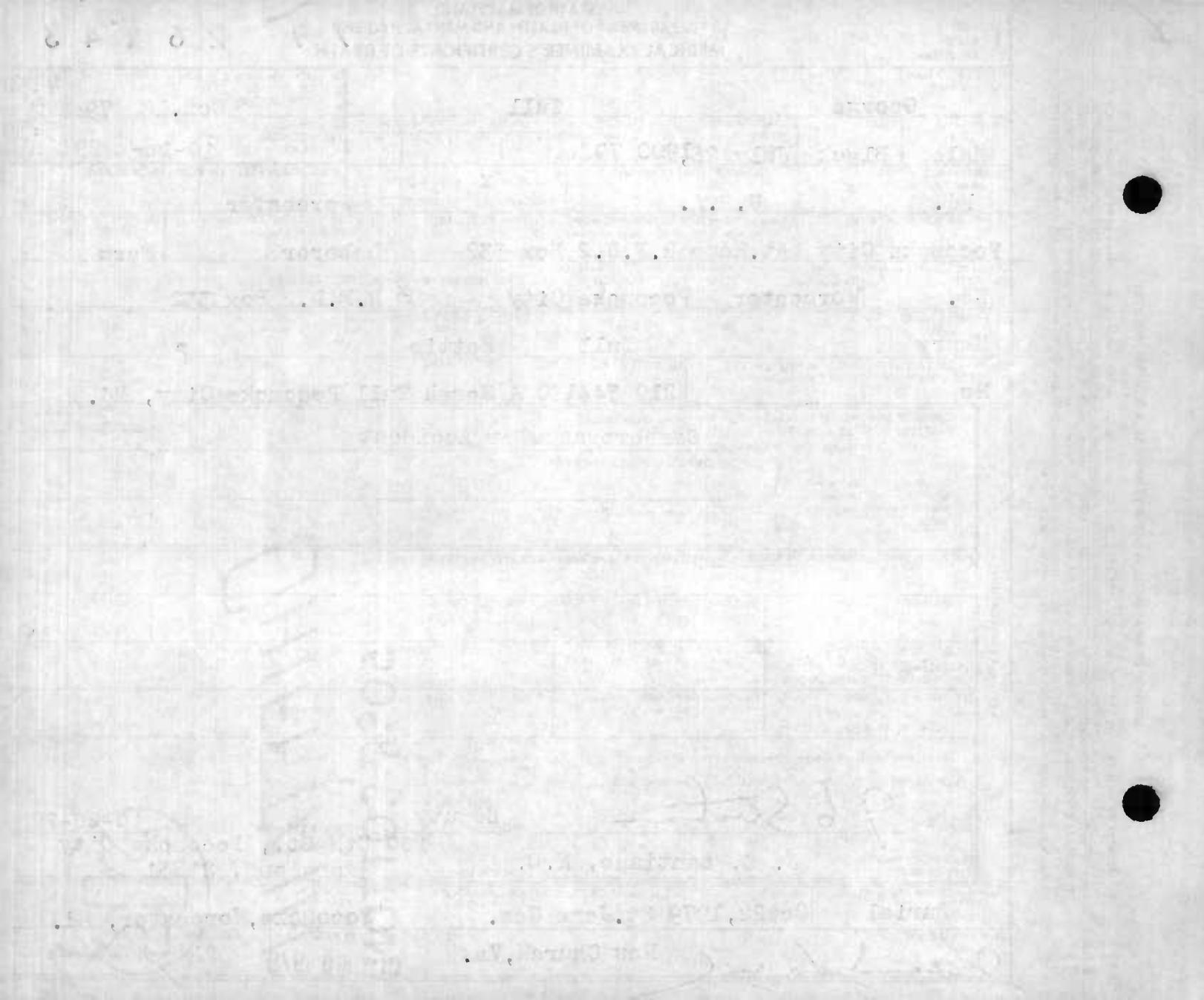
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 79 26442				
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a DATE OF DEATH				MONTH	DAY	YEAR	2b HOUR P.		
LOIS				S.	TAYLOR		October 31, 1979							11:30M		
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS			
female		white		April 29, 1905			74 YRS.				MONTHS	DAYS	HOURS	MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8			9 BALTIMORE CITY OR COUNTY OF DEATH				MD.					
Maryland		USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Worcester									
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS				
Pocomoke		1210 Market Street			13a STATE Maryland			13c. CITY OR TOWN Worcester				1210 Market Street				
14 FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	13d. STREET ADDRESS					
Samuel				Smith	Mary			Mary	Ellen	Redden	1745 Meadowood Court					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT			18a ADDRESS				21040					
no		214-28-8521		Laura Taylor			Edgewood, Md.									
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 410- Conditions, if any, which gave rise to immediate cause (b) <u>Arteriovenous Disease</u> - 4 Weeks underlying cause lost { DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriovenous Disease</u> - 4 Weeks { DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u> Years															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Pickoxes Mellitus</u>																
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
19a		19b			20a			20b								
YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET			CITY OR TOWN	COUNTY	STATE							
22a I certify that (I) (this hospital) attended the deceased from <u>Sept. 19, 1954</u> to <u>Oct. 31, 1979</u> , that (I) (we) last saw the deceased alive on <u>Sept. 9, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b SIGNATURE <u>Charles W. Trader</u>		DEGREE MS	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>Nov. 5, 1979</u>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS														
Charles W. Trader, M.D.		Pocomoke City, Maryland.														
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 11/4/79		23c. NAME OF CEMETERY OR CREMATORIAL Gumby Pres. Cem.			23d. LOCATION CITY OR TOWN Stockton Worcester Md.		COUNTY	STATE						
Burial																
24 FUNERAL DIRECTOR NAME <u>Scott S. Milson</u>		ADDRESS Pocomoke City, Md.			25a. DATE REC'D. BY REGISTRAR NOV 08 1979		25b. REGISTRAR'S SIGNATURE <u>photograph of Brady</u>									



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 9 2 6 4 4 3

1- STATE REGISTRAR		LAST										2a. DATE KNOWN OF ESTI- DEATH MATED		2b. HOUR MONTH DAY YEAR							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		IF UNDER 1 YR. MONTHS DAYS HOURS MIN										Oct. 18 1979 MONTH DAY YEAR		24 HOUR 4 A.M.			
George						7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester		24 HOUR 5 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY), YRS.		2c. DATE PRONOUNCED DEAD 10-18-1979													
Male		Black		July 26 1900		79															
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Worcester		24 HOUR 5 P.M.					
10. CITY OR TOWN OF DEATH Pocomoke City		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At Home R.F.D.2 Box 332										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Farm							
13a. STATE Md.		13b. COUNTY Worcester		13c. CITY OR TOWN Pocomoke City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS R.F.D.2 Box 332													
14. FATHER'S NAME Henry		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME Hattie													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219 344170 A										17. INFORMANT Sarah Tull Pocomoke City, Md.		ADDRESS ?							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> <b>436-</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 19																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE <i>J. G. Santiano</i>		TITLE (SPECIFY) M.D. Deputy												DATE SIGNED 10-20-79							
EXAMINER'S NAME (TYPE OR PRINT) J. G. Santiano, M.D.		MEDICAL EXAMINER 100 8th St., Pocomoke City Maryland, 21851																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct 22, 1979		23c. NAME OF CEMETERY OR CREMATORIAL St. Jame Cem.		23d. LOCATION CITY OR TOWN Pocomoke, Worcester, Md.		COUNTY		STATE											
24. FUNERAL DIRECTOR NAME <i>James S. Sarge</i>		ADDRESS New Church, Va.		25a. DATE REC'D. BY REGISTRAR Oct 29 1979		25b. REGISTRAR'S SIGNATURE <i>John Murphy</i>															
DHMH-17 (VR A15 ME(5)) 15M 7/77																					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

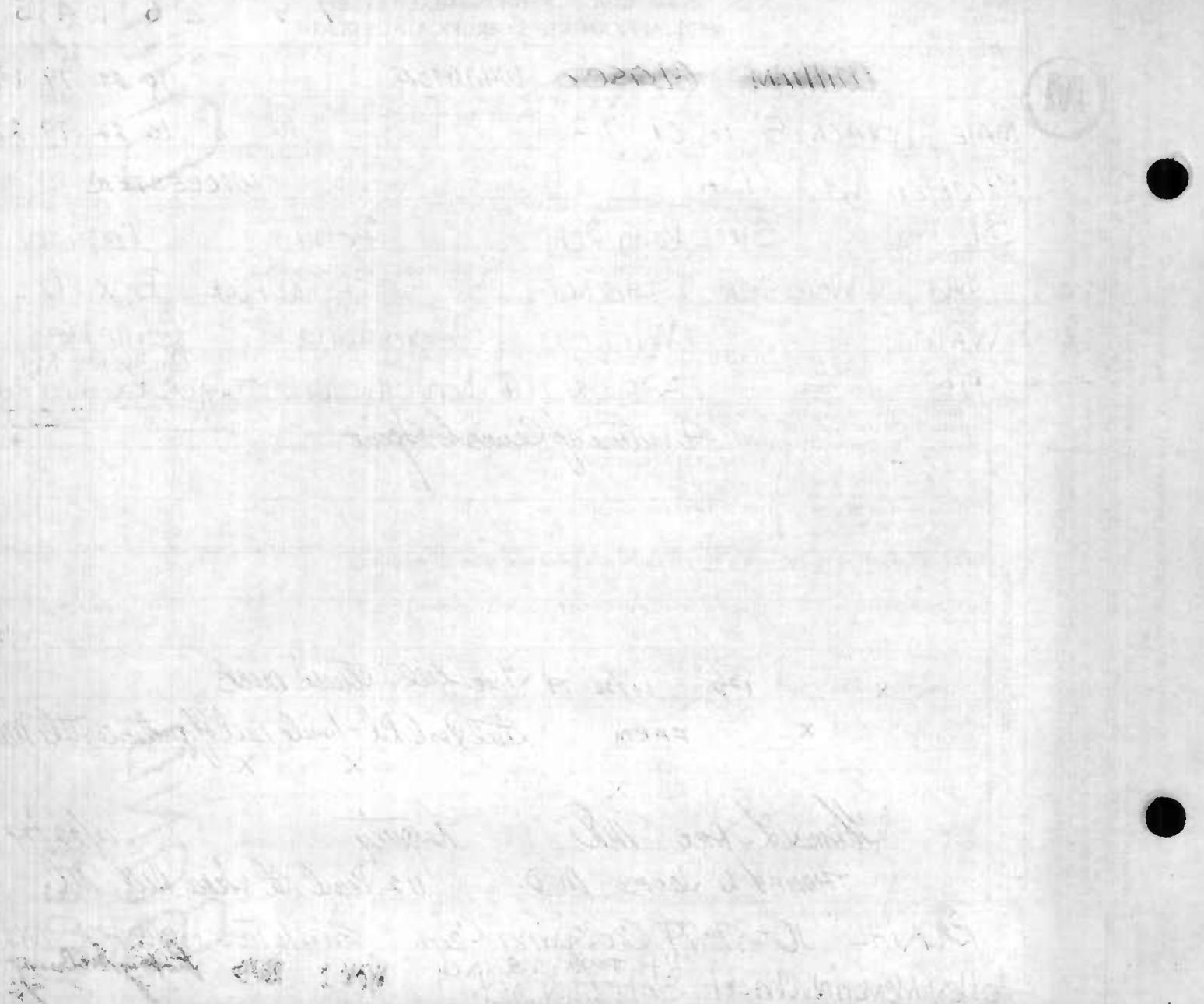
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or see:

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 7 9 2 6 4 4 4			
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR October 15, 1979									2b. HOUR 3 A.M.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST SALLIE	MIDDLE T.	LAST VINCENT	5. DATE OF BIRTH MONTH DAY YEAR June 3, 1893			6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
3. SEX female			4. RACE white												
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Worcester			MD.			
10. CITY OR TOWN OF DEATH Pocomoke			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartley Hall Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired Practical Nurse			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Maryland			13b. COUNTY Worcester	13c. CITY OR TOWN Pocomoke	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Cedar Street							
14. FATHER'S NAME FIRST Charles			MIDDLE R.	LAST Taylor	15. MOTHER'S MAIDEN NAME Lucy			16. SOCIAL SECURITY NO. 219-05-9370			17. INFORMANT Sarah Hicks ADDRESS 6420 Sherwood Road Baltimore, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 410			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)												
{			{												
DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from 10-15 1979 to 10-15 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.															
22b. SIGNATURE J. G. Santiano			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 10-16-79						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. G. Santiano			22e. ADDRESS 100 8th St. Pocomoke City, Md. 21851												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/17/79			23c. NAME OF CEMETERY OR CREMATORIAL Downing Meth. Cem.			23d. LOCATION CITY OR TOWN Oak Hall			COUNTY Accomack	STATE Va.		
24. FUNERAL DIRECTOR NAME Scott S. Melson			ADDRESS Pocomoke City, Md.			25a. DATE REC'D. BY REGISTRAR OCT 22 1979			25b. REGISTRAR'S SIGNATURE Henry Melson						

65 15

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.	9	26445						
1- FOR STATE REGISTRAR			LAST									2a. DATE KNOWN OF ESTI. DEATH			MONTH	DAY	YEAR	2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			<b>WILLIAM GLASCO WHARTON</b>			<input checked="" type="checkbox"/>	10	22	1979	1:30 PM	
SEX	4 RACE	S. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY			7. IF UNDER 1 YR. MONTHS DAYS			8. IF UNDER 24 HRS. HOURS MIN			2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR		
MALE	BLACK	8 18 01	78 yrs.									10 22 1979						28 M		
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?									8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH					
Stockton-Md			USA									<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			WORCESTER					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Stockton			Steel Pond Road									Retired			Carpentry					
13a. STATE			13b. COUNTY			13c. CITY, OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS								
Md			Worcester			Stockton						Rural Route Box 110								
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST								
Walha						Wharton			Georgianna			Gillette								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.									17. INFORMANT			ADDRESS					
No			220-46-7478									Kenneth Wharton			Girdtree Md, Taylor Landing Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
IMMEDIATE CAUSE (a) <i>Fracture of Cervical Spine</i>																				
DUE TO, OR AS A CONSEQUENCE OF																				
(b) <i>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.</i>																				
(c) <i></i>																				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?								
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 20 PART I OR PART II)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			1:30 P.M. 10/22/79			Free field stuck neck														
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION																	
FARM			Stal Pond Rd - 1 mile east of junction of Little Mill rd																	
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes			Accident <input checked="" type="checkbox"/>			Suicide <input type="checkbox"/>			Homicide <input type="checkbox"/>			Autopsy <input type="checkbox"/>			Inspection <input checked="" type="checkbox"/>			Inquiry <input checked="" type="checkbox"/>		
ACTUAL SIGNATURE <i>Thomas L. Jones, M.D.</i>			M.D.			TITLE (SPECIFY) <i>Deputy</i>			Undetermined manner <input type="checkbox"/>			and in my opinion								
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS <i>112 Pearl St. Shaw Hill, Md.</i>																	
23a. BURIAL/CREMATION/REMOVAL (CHECK ONE)			23b. DATE 10-27-79			23c. NAME OF CEMETERY OR CREMATORIUM Coolspring Cem.			23d. LOCATION CITY OR TOWN <i>Girdtree-Worcester, Md.</i>											
24. FUNERAL DIRECTOR ADDRESS <i>Holley Memorial Chapel</i>			25a. DATE REC'D. BY REGISTRAR <i>NOV 1 1979</i>			25b. REGISTRATION SIGNATURE <i>Henry McElroy</i>														
BP _____																				
DHMH - 17 (VR A15 ME (5))																				
15M 7/76																				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NEEDED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL ALONG PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA. RETAIN PAGE 5 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 79-26446						
1. FOR STATE REGISTRAR			FIRST MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH			2b. HOUR						
1. DECEASED NAME (TYPE OR PRINT)			ROBERT			YAFFE			<input checked="" type="checkbox"/> MONTH DAY YEAR			10 19 79 43P						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR		2d. HOUR				
Male		White		Feb 16, 1928		51 yrs.						10 19 79		58M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Maryland			USA						WORCESTER									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Berlin, Md. R.F.D.			Isle of Wight Medical Center, Rt. 90 + Isle of W. Rd.			Wholesaler			Candy & Tobacco									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13. CITY OR TOWN			13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS									
Maryland			Montgomery			Bethesda			8504 Burning Tree Road									
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes Korean War			16b. SOCIAL SECURITY NO. 220-20-2211			17. INFORMANT Harriet L. Yaffe, 8504 Burning Tree Road			ADDRESS Bethesda, Md.			
Abraham H. Yaffe			Bessie ----- Bernstein															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 410- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause first.			Acute Myocardial Infarction			DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Cardiovascular Disease									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(b) DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Cardiovascular Disease																		
(c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?												
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																		
ACTUAL SIGNATURE			THOMAS L. JONES, M.D.			TITLE (SPECIFY) A.D. Deputy MEDICAL EXAMINER			DATE SIGNED 10/20/79									
EXAMINER'S NAME (TYPE OR PRINT)			THOMAS L. JONES, M.D.			ADDRESS #1493 Est. Ocean City, Md.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Oct. 22, '79			23c. NAME OF CEMETERY OR CREMATORIUM Nat'l. Mem. Park			23d. LOCATION CITY OR TOWN			23e. COUNTY			STATE			
Burial									Falls Church, Virginia									
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REG. DATE & CERTIFICATION									
DANZANSKY-GOLDBERG CHAPELS			1170 Rockville Pike															

